Maryland Health Care Reform Coordinating Council

Entry into Coverage Workgroup

White Paper

October 31, 2010

Charge

One of the fundamental goals of the Affordable Care Act (ACA) is to reduce the number of the uninsured. Health care reform expands insurance coverage though several different strategies: it expands Medicaid[1]; offers premium subsidies to individuals with incomes above the Medicaid level[2]; imposes a requirement that individuals maintain health insurance enforced by a federal tax penalty[3]; and creates new health insurance exchanges to facilitate the purchase of insurance.[4] There are also subsidies for some small employers and penalities for employers that don't offer insurance. Together, these strategies create a "culture of insurance" where virtually everyone is expected to have health insurance through public or commercially available health insurance.

Estimates are that these combined strategies will cut the number of uninsured by half in Maryland.[5] But achieving these goals depends largely on the State's ability to enroll people in the new and existing coverage options available to them. Many implementation decisions are left to states. Some of these decisions will create the foundation for how Maryland will connect people to coverage and the extent to which ACA's goals of expanding insurance coverage and reducing the number of uninsured are met. In its Interim Report, the Health Care Reform Coordinating Council (HCRCC) charged the Entry into Coverage Workgroup with identifying options for Maryland to consider in its approach of Entry into Coverage. These encompass both eligibility and plan enrollment:

1. Eligibility -- The structure, process and policies to determine eligibility for individuals in Medicaid, the Maryland Children's Health Program (MCHP) and income-based premium credits offered through an Exchange; and

2. Enrollment - The point of access for individuals and small businesses to enroll in health plans offered through the Exchange.

The structure and goals of the Exchange are within the purview of a separate workgroup, Exchange and Insurance Markets. There are a number of decisions about the Exchange that are fundamental to developing options for Entry into Coverage: What will be the goals of the Exchange? What functions will actually be performed by an Exchange or be left to the current

[1] P.L. 111-148: §2001 as modified by §10201; P.L. 111-152: §1004 and §1201

[2] P.L. 111-148: §1401-15, §10105, as amended by §1001 and §1004 of P.L. 111-152

[3] P.L. 111-148: §1501(b) as amended by §10106 (b) of and by §1002 of P.L. 111-152

[4] P.L. 111-148: §1311(b)(1)(B) discusses a state option to operate two exchanges (an individual exchange and a SHOP [Small Business Health Options Program]exchange) or consolidate as one.

[5] Health Care Reform Coordinating Council (July 2010). *An Interim Report*. Retrieved from http://healthreform.maryland.gov/documents/100726appendixf.pdf

private sector mechanisms for enrolling people into coverage? The Exchange and Insurance Markets Workgroup is beginning a process to examine options, but it is likely that much uncertainty will remain about how Maryland will choose to implement an Exchange. In its Interim Report, the Council called for a consumer-centric approach to both care and coverage that provided seamless transition between eligibility determinations and enrollments. Achieving this goal will require that eligibility and plan enrollment process are connected. The Council will need to evaluate the Entry into Coverage options presented in this paper in the context of options being considered by the Exchange and Insurance Market Workgroup. The on-going health reform implementation efforts will need to align the future decisions in these areas.

Process

The Entry into Coverage Workgroup was co-chaired by Brian Wilbon, Interim Secretary of the Department of Human Resources, and John Folkemer, Deputy Secretary of Health Care Financing, Department of Health and Mental Hygiene. There was no assigned membership. In an effort to be as inclusive as possible, participation in the workgroup was open to any interested party.

The workgroup met four times between August 2010 and October 2010. The goal of the first meeting was to review the charge, provide background information and overview of current enrollment system, and present an overall work plan. The co-chairs solicited feedback, to include any gaps in the conceptualization of the enrollment system or focus of the work plan. The goal of the second meeting was to listen to oral and written testimony from various stakeholders to highlight issues to be taken into consideration when framing the enrollment system to new federal standards in 2014. The goal of the third meeting was to present the first draft of the white paper, which reflected the public comments as well as a basic structure of Maryland's new enrollment and eligibility system. Feedback was solicited to ensure the draft white paper accurately reflects the scope of the public input. The goal of the fourth meeting was to present an updated iteration of the report and to solicit any remaining comments.

Background on Issues

Federal guidance is still pending on a number of issues that are important to state implementation efforts. Federal regulations on eligibility issues were expected by the Fall of 2010, but have not been released to date. Until regulations are released, states do not know the essential requirements of the new systems. One of the most significant outstanding federal decisions is whether the states will be required to track Medicaid eligibility under current rules as well as the new streamlined rules for 2014. If the federal government requires states to track this information for the purposes of federal matching formulas, efforts to streamline eligibility could be thwarted.

Federal policy makers are considering the possibility of providing either standards for eligibility system development or possibly components of an eligibility system to states through the use of open source software or common systems. While this could significantly assist state efforts, the uncertainty about what assistance will be offered is complicating state planning efforts. Even if the federal government provides some systems, states would still be required to complete significant information system changes as well as implement and integrate a 'common system' with existing systems.

The data exchange standards and details of how verifications will be streamlined through connections to the IRS and other federal databases have yet to be determined. In addition, a simplified common application form across health programs is to be developed by the federal government.[6] The data elements and structure of this application will also impact information system development.

Although there are a number of uncertainties about implementation, the development of eligibility and enrollment systems takes significant lead time and state implementation efforts must begin immediately. The Entry into Coverage Workgroup is basing its planning efforts on the assumption that the streamlined connections to the IRS and other federal databases will be realized so that the possibility of real time eligibility determinations through a simplified process is achievable.

Options

This section of the paper summarizes the options proposed by public comments as well as options developed by Agency staff for which guidance is needed despite a lack of comment. The majority of comments focused on the process for determining income based eligibility for Medicaid, MCHP and premium credits. Several common themes emerged as goals for Maryland's Entry into Coverage implementation.

- Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;
- Eligibility determinations should be integrated and seamless (across both health and public assistance programs);
- Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HRCCC;

[6] P.L. 111-148: §1413

- There should be a "No Wrong Door" approach to applying for coverage (across both health and public assistance programs).
- Eligibility and enrollment into health plans should be part of a continuous process rather than distinct systems.

1. *Structural options: Eligibility Determination for Medicaid, MCHP and Premium Subsidies for Plans Offered through Exchange*

ACA requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all health programs.[7] State Exchanges have the option to contract with State Medicaid agencies to determine income based subsidies under the Exchange. Regardless of where the function is housed, Maryland has two basic structural options: Create a point of entry for consumers to health programs, managing eligibility determinations for Medicaid, CHIP and Premium Credits for Exchange products in one place; or Build on the existing health and public assistance model for Medicaid and public assistance and coordinate with eligibility determination for Premium Credits through the Exchange.

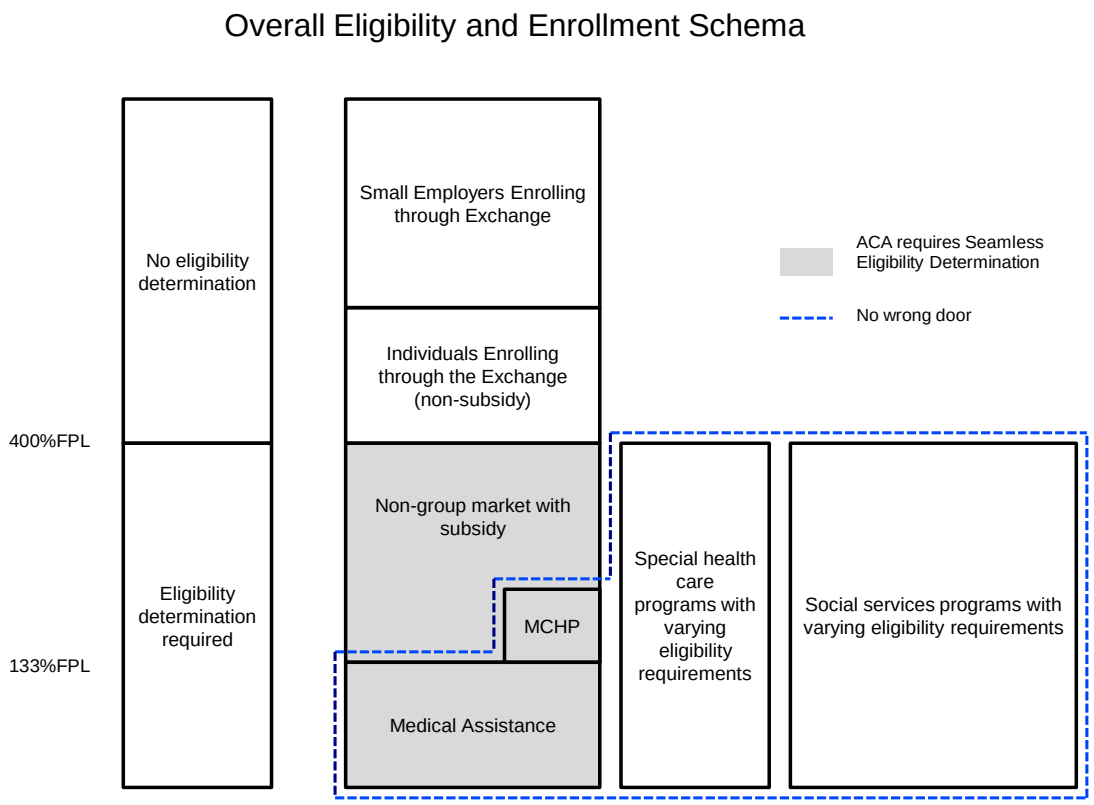
Maryland's current process for determining eligibility for Medicaid has evolved over a 40 year history of changing public assistance programs and Medicaid expansions. Today, about 1,600 staff at 24 local Departments of Social Services, 24 Local Health Departments and at Maryland's Department of Health and Mental Hygiene (DHMH) review and approve applications. The Client Automated Resource and Eligibility System (CARES) supports the eligibility determination for the majority of Medicaid and MCHP enrollees, but some groups' eligibility is determined outside of the CARES system. In addition, the CARES system determines eligibility for other social programs sucs as food, cash and energy assistance, and provides an integrated care for those individuals with eligibility in multiple programs. Local Departments of Social Services, Health Departments, and DHMH all use CARES system to support current operations

The Service Application and Information Link (SAIL) system is a web-based system that is available via the Internet to the public. Today, 8.5 percent of all Medicaid applications and 17.8 percent of all MCHP applications are received through SAIL. The SAIL system is a tool available to consumers to apply for benefits electronically for most Medicaid programs, food assistance, cash assistance, and energy assistance. SAIL has an interface with the CARES system, providing a transfer of the application data into the eligibility system without the re-entry of data. Some comments said that in its current state, SAIL is insufficient as a screening tool and simplified enrollment tool. .

[7] P.L. 111-148: §2201

Virtually all comments to the Entry into Coverage Workgroup called for seamless eligibility determinations through an integrated eligibility system. Some even called for a co-locating of eligibility staff. The challenge for Entry into Coverage implementation is how to achieve seamless enrollment to health coverage programs across the income scale as envisioned by ACA as well as coordinating eligibility determination process for related health and public assistance programs (Chart 1). Many comments urged the state to coordinate eligibility for all of these programs at the start of any new system.

Chart 1. Coordination of Eligibility Determinations



2. *Central vs. Local Eligibility Determinations*

Today, Medicaid and MCHP applications are accepted by mail, in person and through web-based applications. The applications are processed by 1,600 staff in 24 Local Departments of Social Services, 24 Local Health Departments and DHMH. There was consensus that there will continue to be a need for a local eligibility and enrollment assistance; however, the role of the traditional case worker may change as more automated systems proactively determine eligibility.

This local role may be able to focus on assisting with more complicated Medicaid eligibility cases, such as long term care and home and community-based waiver eligibility, and connecting individuals to a broader range of services and public assistance programs. The local role would need access to tools, such as a health portal or more comprehensive access to the eligibility system of record, to facilitate enrollment into Medicaid, Maryland Children's Health Program (MCHP), or Premium Credits.

A centralized administrative system could manage eligibility determinations that are based on applications that come in other than in person (mail, fax, phone, and web). This centralized system could manage data-driven eligibility determinations such as automated feeds of IRS information on prior-year income data.

These options will need to be more fully vetted when federal guidance is provided and more is known about what eligibility determinations will actually be supported by automated systems. Maryland is estimated to have over 1 million individuals enrolled in Medicaid by 2015. Even with new automated strategies, this new caseload as well as current staffing levels will likely mean that new staff will be required.

3. *Use of Modified Adjusted Gross Income Standards (MAGI)*

Today, states use a number of different standards to calculate income for the purpose of Medicaid eligibility. States use different policies to calculate income and use different income disregards in setting their eligibility thresholds. ACA requires all states to use Modified Adjusted Gross Income (MAGI) as the way to calculate income for eligibility determinations for Medicaid, MCHP and subsidies through the Exchange.[8] All states are required to apply a standard 5% disregard so that income disregards are also standardized. In some respects, this will simplify the eligibility determination process because MAGI can be calculated from Adjusted Gross Income which is a line item on an individual's tax return. ACA assumes electronic verification of income will occur through linkages with the IRS. These new requirements will change the concept of eligibility determinations with computer systems providing more ability to make real-time determinations based on electronic sources of verification.

In other respects, the change to MAGI will complicate eligibility determinations. MAGI provides household income in the prior year, but may not reflect current circumstances. Therefore, processes to gather current information will need to be established. Some low-income individuals do not file taxes and systems will need to consider how to process their eligibility. Some stakeholders called for standardized eligibility rules and income definitions across

[8] P.L. 111-148: §2001 as modified by §10201; P.L 111-152: §1004.

programs. The use of MAGI will support the standardization across health programs (Exchange, Medicaid and MCHP), but it would be more difficult to standardize income definitions across public assistance programs and even within some Medicaid eligibility groups.[9]

Although there was little comment from stakeholders, one of the challenges of the eligibility process will be the interface with a federal tax credit process. The federal tax credit is advanceable[10], meaning that applicant can elect to receive the tax credit immediately, which will have the effect of reducing the upfront premium costs. How an individual will agree to accept the advanceable credit will be important to consider because it will affect the eligibility determination process.

4. *Websites*

ACA maximizes the role of the internet in applying for and renewing coverage. HHS launched a website on October 1 that provides information on health plans available in each state and links to enrollment information on Medicaid and MCHP.[11] This website will be refined and ultimately linked to Exchanges for enrollment information. By 2014, States are also required to operate an internet website that links the Exchange, Medicaid and CHIP. This website must allow individuals to compare plans and apply for and renew coverage.[12]

Today, Maryland has a web-based application for Medicaid and MCHP and public assistance programs, but some other health programs are not currently supported by a web-based application. Maryland is developing a web-based health application that combines applications for Medicaid, MCHP, the Primary Adult Care Program and local health initiatives and links to SAIL and CARES for eligibility determinations. A website that supports consumers in applying for coverage is both required by federal law and advocated for by most stakeholders.

The website will be an important way to reach consumers and could serve many functions: providing information about health programs and a means to apply, screening tools and decision

[9] Per P.L. 111-148: §2001; certain groups are exempted from income eligibility determinations based on MAGI. They are (1) individuals who are eligible for Medicaid through another federal or state assistance program, such as foster care; (2) the elderly; (3) certain disabled individuals eligible for SSI; (4) the medically needy and (5) enrollees in a Medicare Savings Program.

[10] P.L. 111-148: §1412(a)(3).

[11] P.L. 111-148: §1103, as amended by §10102

[12] P.L. 111-148: §2201

tools that give consumers real time information, comparative information about health plans and choices.

Some comments expressed a concern that implementation of Entry into Coverage strategies could not rely solely on web-based strategies because many low-income and vulnerable populations do not have access to internet. Computer literacy varies tremendously and websites need to be developed in accessible formats. Web resources need to be written at no more than a 4th grade reading level and include translation into prominently spoken languages. The website should be tested with diverse consumers before launching the site.

5. *Assistance with Eligibility*

ACA calls for states to provide assistance to individuals to apply for and enroll in health plans. ACA requires Exchanges to set up Navigators[13] to provide fair and impartial information regarding enrollment in health and subsidies. States are required to establish procedures for conducting outreach and providing enrollment assistance to vulnerable and underserved populations.[14]

There is broad consensus that Maryland should use a diverse network of existing community based organizations with a track record of trust in their community to assist individuals to enroll in health coverage programs. Massachusetts' experience with small grants to community based organizations was cited as a model that many wanted to pursue. This concept is thought to be particularly important for special populations that may rely on specific community based organizations for assistance. Some commented on the need for on-going stable financing to support the community assistor activity. Effective training and tools (health portals) to support community based organizations will be necessary.

Some suggested the use of out-stationed eligibility workers to facilitate enrollment. As systems are developed and it becomes clearer what the role of eligibility workers will be in a new technology enabled system, this option should be evaluated.

As health coverage is expanded both through Medicaid and new products offered through the Exchange, additional strategies to assist people with eligibility should be considered. Implementation plans should consider how to coordinate the different roles of assistors: case

[13] P.L. 111-148: §1311(i)

[14] P.L. 111-148: §2201

workers, brokers and agents, community based organizations, and ombudsman and care coordinators. It is important that these assistors represent the communities they will serve.

6. *Hotline/Helpline*

Many stakeholders called for a well staffed and trained hotline or helpline to be available to consumers for information on programs and how to apply. The telephone helpline/hotline could serve as an important resource for consumers in answering questions about availability of benefits. ACA also cites the telephone as one of the mechanisms for individuals to apply for coverage.[15] The hotline/helpline is an important compliment to outreach and education strategies. This hotline/helpline needs to be well trained and staffed to support the outreach and education efforts that may precede plan enrollment and may need enhanced staffing at peek times. The helpline/hotline staff also need to be trained to provide culturally appropriate services and have the capability to link individuals with limited English proficiency with needed resources. Consumers should have a variety of ways to get follow-up information, including the telephone and website.

7. *Strategies to Achieve No Wrong Door Goals*

No Wrong Door refers to a service system that welcomes people in need and assists them to connect with desired services regardless of the agency where they try to gain access. In simple terms, it means that consumers should be able to get information and apply for programs wherever they are – at a local health department, department of social service or when they are seeking health care services or other services.

ACA requires a "no wrong door" approach to eligibility determinations for income based health programs (Medicaid, MCHP, Exchange Subsidies).[16] Some changes to the eligibility determination process for health programs will make the linkage with public assistance more challenging. However, there are opportunities to use the changes to the eligibility determinations process for health to make it more seamless with related public assistance programs. These include:

a. Effective and simple screening tool for programs (health and public assistance) – A screening tool that enables consumers to input basic information and be prompted to ask questions that would allow a determination of eligibility for a broad range of

[15] P.L. 111-148: §1311(d)(4)(B)

[16] P.L. 111-148: §1413

programs is an important tool for case workers, community assistors or consumers to get the information they need about a broad range of programs and their potential eligibility. An effective screening tool could empower consumers, community assistors and case workers for a range of programs to provide information and assistance to the consumer. The SAIL system already provides this screening tool for many programs through its "Am I eligible" calculator, which determines potential eligibility based on consumer responses to a few questions.

b. Document Management and Verifications – One of the barriers to enrollment in both health and public assistance programs is the difficulty individuals have collecting and providing documentations of income, immigration status, citizenship or other required materials. A shared document management system could ease the barrier to enrollment by allowing information to be provided once and shared among health and public assistance programs. There are other states that use data driven document verification strategies and these should be explored. It is also assumed that new avenues will be available to verify income for health programs through linkages with the IRS that will reduce barriers to enrollment related to income verification.

c. System to Check Status of Eligibility Determinations – Some stakeholders proposed a system that would allow consumers or community assistors access to real-time information on the status of their eligibility determination for health and public assistance programs. This system could provide information on documentation that is missing or information that is needed to complete the eligibility determination process. This concept applies to both health and public assistance programs.

d. Single Streamlined Application - ACA requires HHS to develop a single streamlined application form that can be used for applying for subsidies under the Exchange, Medicaid or MCHP.[17] States may develop their own single form as long as it meets the same standards. Some suggested the advantage of having a common application between health and public assistance programs. The federal requirements regarding the streamlined health subsidy application may make it challenging for health and public assistance to share the same application form; however, the concept that the health application could be the basis of an application and other programs would develop modules for information specific to their program is worth pursuing once more is known about what the Federal application will require.

[17] P.L. 111-148: §1413

e. Express Lane Eligibility - Prior federal law (CHIPRA) gave states the option to allow children express lane eligibility, allowing Medicaid and CHIP eligibility requirements to be satisfied based on the data from other government agencies. This means states could deem children eligible even if there are technical differences in how income is evaluated across programs. ACA preserves this opportunity, exempting express lane strategies from the new MAGI income definition.[18] Express lane strategies could allow children who are eligible for SNAP to be automatically deemed eligible for Medicaid or MCHP. Express lane strategies should be evaluated as another approach to achieving no wrong door policies.

The General Assembly approved budget language requiring a study of No Wrong Door policies across a broad range of public assistance programs. The implementation of health reform should work in collaboration with the efforts of this group.

8. *Policy Issues to Expedite Eligibility Determinations or Maintain Coverage*

Current federal law allows states to use presumptive eligibility for pregnant women and children. ACA extends this definition, giving states the options to allow this option for additional populations.[19] In addition, it allows hospitals to conduct presumptive eligibility.[20] This is an option to consider and some stakeholders called for this strategy to maximize coverage options. Clear and simple criteria for determining a person's eligibility for Medicaid, based on readily accessible information, will facilitate hospitals' ability to accurately determine eligibility.

One of the challenges with Medicaid is that individuals churn on and off of coverage as their income and other circumstances change. A number of stakeholders called for 12-month guarantee of eligibility to reduce churning of individuals on and off of Medicaid, MCHP, or Exchange subsidy coverage. Some called for implementing this prior to 2014 reforms. Under Maryland's current eligibility policy, when an individual is determined Medicaid eligible, they are enrolled for 12 months. However, individuals are required to notify their case worker when they have a change in circumstance which may affect their eligibility. There is an annual redetermination process which verifies their continued eligibility. Medicaid enrolled individuals who are eligible for other programs such as Supplemental Nutrition Assistance Program are required to reapply for coverage more

[18] P.L. 111-148: §2001 and §2002 as modified by §10201

[19] P.L. 111-148: §2001 as modified by §10201

[20] P.L. 111-148: §2202

frequently. A 12-month guarantee of eligibility would maintain individuals on Medicaid regardless of whether they continue to meet eligibility requirements. Until 2004, Maryland guaranteed eligibility for 6 months for all individuals enrolled in HealthChoice except those who were paying premiums through MCHP premium. This policy was discontinued for cost containment reasons. A policy to guarantee eligibility for 12 months just for children has been estimated to be $58 million.[21]

Under federal rules, individuals who are incarcerated are not eligible for Medicaid services. However, they may be eligible for Medicaid after they are released and Medicaid coverage can play an important role in re-entry programs, including maintaining their access to mental health or addictions treatment. The current Maryland eligibility system requires individuals to re-apply for Medicaid after they are released from incarceration, which can be a long and cumbersome process. Another option to facilitate continuity of care and support re-entry efforts is to "suspend" Medicaid eligibility during a period of incarceration. This would ease the administrative barriers to health care for those who were previously enrolled in Medicaid and who were incarcerated for a short period of time. If they were released within their Medicaid eligibility span (normally one year), the suspension would be lifted and Medicaid eligibility continues for the remainder of the span. Another suggestion was made that Medicaid work with Public Safety and Correctional Services to screen all prisoners released for Medicaid eligibility. A screening for the Primary Adult Care program already occurs. This would ensure health coverage and support re-entry efforts.

Strategies to improve retention during the recertification process were suggested, including pre-populating recertification forms.

9. *Data Driven Enrollment*

ACA requires linkages with the IRS to streamline eligibility determinations for subsidy programs, Medicaid and MCHP.[22] This will streamline the application process, making determinations more real-time. More federal guidance is needed about how this will work. Consensus among stakeholders was that in addition to linkages to the IRS, other data driven strategies in which consumer are determined eligible based on existing data

[21] Maryland Department of Health and Mental Hygiene (December 2009). *2009 Joint Chairmen's Report: Report on Barriers to Enrollment at the Community Level*. Retrieved from http://www.dhmh.state.md.us/reports/pdf/2009/dec09/Medicaid/100_MA_Enrollment_Barriers.pdf

[22] P.L. 111-148: §1311(c)(3-6), (d)(4)

should be pursued. These data matching efforts could help identify all available coverage options for individuals. In addition, it was noted that legislation may be necessary to give DHMH authority to use all necessary state administered data files (such as the state wage files, and Motor Vehicles records) for electronic verifications of individuals applying for Medicaid, the subsidized exchange, or other state health programs.

10. *Empowering Consumers*

Effective Entry into Coverage strategies require that consumers know how to use the system. They need clear information on the availability of assistance, the value of the benefits that coverage programs provide, and how to apply on their own or get help when they want it. The Entry into Coverage outreach efforts will need to include consumers, providers, insurers, non-profits and the general public. The communication and outreach strategy should be addressed early in the planning process and adequately funded. Racial and ethnic minorities should be active participants in the planning process.

The importance of clear communications and the need for materials on 4th grade reading level and translations at the 4th grade level were cited. Other comments focused on the need for local input on media strategies because different strategies work in different communities. Furthermore, there was an emphasis on ensuring racial and ethnic minorities are part of the planning and development process. This involvement would greatly facilitate the cultural competency and assuring that materials are culturally appropriate and sensitive

The web resources discussed above will be an important part of reaching consumers. There are a number of additional creative strategies identified by stakeholders that hold the potential to make it easier for individuals to apply for coverage. Many of these could be low-cost and low-tech solutions to making eligibility determinations more accessible. They include:

a. Kiosks at diverse locations that provide information on health programs, applications for coverage and a way to submit the application.

b. Applications, Copiers and Drop Boxes located at public assistance offices and other locations would allow consumers to apply quickly without meeting with a case worker. This strategy was successfully employed by Delaware.

c. Fee waivers for documentation make it feasible for low-income consumers to gather necessary documentations.

d. Mobile offices in low income neighborhoods or rural areas could provide information and application assistance on programs.

11. *Early Expansion of Medicaid*

Some stakeholders called for an early expansion in Medicaid (such as an expansion to 50 percent of the FPL for childless adults to reduce the ramp-up of this population in 2014). An early expansion t would let the state phase-in what is likely to be a significant expansion and would simplify the eligibility process for individuals with disabilities even before health reform is fully implemented. Others cautioned that restoring prior provider reimbursement reductions is important before expanding coverage further.

12. *Address Broad Medicaid Eligibility Issues*

The workgroup focused on eligibility for individuals whose eligibility is affected by reform. This includes the Families and Children Medicaid groups, MCHP and individuals eligible for premium credits through the Exchange. There are about 150,000 individuals enrolled in Medicaid as Aged, Blind and Disabled (ABD) groups. Eligibility for ABD Medicaid can be complicated because it may require a disability determination process, which can be lengthy. Health care reform may provide some relief to eligibility backlogs for ABD because some individuals will now be determined eligible based on their income and will no longer have to demonstrate their disability. Several comments were provided that urged improvements in the eligibility process for the Aged, Blind and Disabled categories of Medicaid. Placing more out-stationed eligibility workers in hospitals was suggested. The current systems for determining eligibility for nursing home care was cited as flawed and not meeting the goals of the ACA.

Immediate Issues (Next 12 Months)

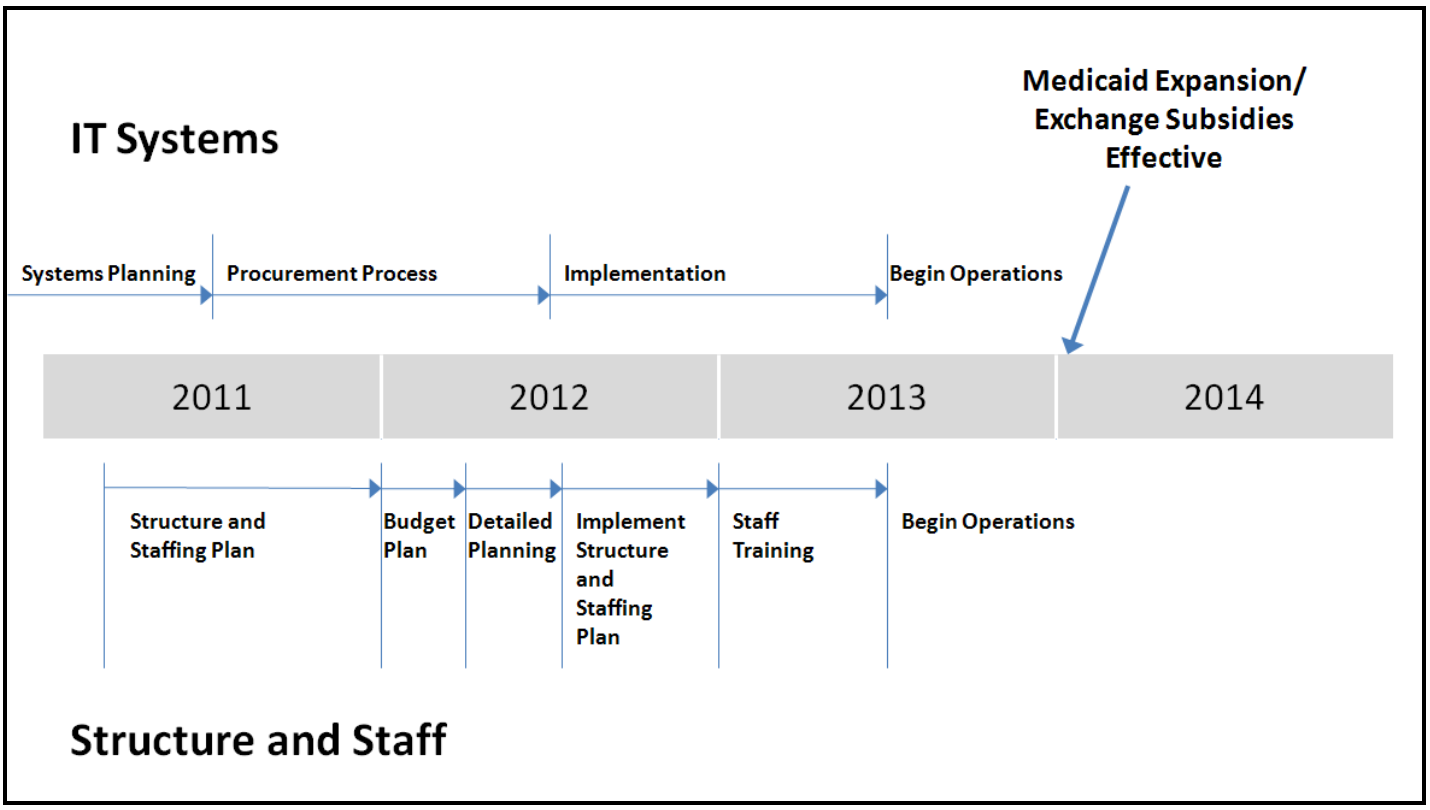
Maryland stakeholders have identified a number of encouraging options and strategies that could be part of an overall approach to Entry into Coverage that achieves the goals of simplifying the eligibility process; making eligibility integrated and seamless; embracing a culture of insurance; advancing no wrong door efforts; and connecting eligibility and plan enrollment. Many of these issues are inter-related and will depend largely on federal guidance and state decisions related to the goals and functions of an Exchange.

The challenge for Maryland and all states is that many implementation activities require significant systems changes which have long lead times in planning, procurement and

implementation. The Entry into Coverage Workgroup was asked to focus on the immediate issues that Maryland will need to address for successful implementation in the next 12 months. While this paper identifies many issues that will ultimately need to be considered, there are two fundamental decisions that will need to be made in 2011 because they are foundational to reform implementation: 1. the goals and functions of information systems; and 2. structural decisions related to eligibility determination and plan enrollment.

The timeline below illustrates these foundational decisions need made regarding IT systems and structure in 2011 because they impact procurement decisions or FY 2013 budget issues.

Chart 2. Timeline of Decisions for IT Systems and Structure



More information about federal requirements and the feasibility of technical options are needed before decisions can be made on IT systems and the structure for eligibility systems. On September 30, 2010 Maryland received a federal planning grant that will contribute to Maryland's effort to further develop these options. The $999,227 Health Insurance Exchange Planning grant will be largely allocated to evaluating different technical options available to Maryland. These resources will allow Maryland to fully examine technical options, including

the best practices and systems from other states. The first phase of this planning work is planned to be completed by July 2011 so that necessary procurement processes can begin.

These federal planning funds will support some of Maryland's implementation efforts, but there will be a potentially significant cost to implementing these system changes. It may be challenging to ensure that sufficient funds are available to build and maintain a modified system. With uncertainty about necessary system changes and how much the federal government will contribute, it is impossible to predict the implications for the state budget.

The workgroup has provided invaluable direction in guiding the continued planning process. This paper provides a direction for the ultimate goals for Entry to Coverage:

1. Income based eligibility determination policy and process should be dramatically simplified relative to the current policy and process for Medicaid and MCHP;
2. Eligibility determinations should be integrated and seamless (across both health and public assistance programs);
3. Eligibility policy and process should reflect the culture of insurance (where all individuals have insurance coverage as required by the federal mandate) envisioned by ACA and called for in the Interim Report of the HRCCC;
4. There should be a "No Wrong Door" approach to applying for coverage (across all health and public assistance programs).
5. Eligibility and enrollment into health plans should be part of a continuous process rather than distinct systems.

Achieving all of these goals by 2014 is a tall order. Given our current information on federal rules, potential federal systems and more detailed technical analysis, it is premature to decide what system changes should be made. In the next several months, Maryland can use these federal grant resources to evaluate what is technically feasible to accomplish by 2014. With this assessment we will better understand how far Maryland can progress towards achieving these goals or how immediate system changes could be a part of longer term strategic vision for Entry to Coverage.